Metro Nashville Human Resources

Annual Enrollment Guide for 2005 Benefits

Oct. 11 to 29, 2004

Inside the Guide

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About This Guide

The Annual Enrollment Guide provides a variety of information to help you enroll in your Metro employee benefits for 2005. If the information in this Guide differs from the official plan documents, the plan documents will govern. This Guide does not constitute an offer of employment or a promise to provide any particular benefit. Metro Nashville reserves the right to change its employee benefit program at any time. For more information, call Metro Human Resources at (615) 862-6700.

Americans with Disabilities Act Statement
To request an alternative copy of this guide,
call Metro Human Resources at (615) 862-6640.

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2005 Benefit *Resources* Directory

Benefit	Contact	Website	Phone
Medical PPO	BlueCross/BlueShield PPO	www.bcbst.com	(800) 367-7790
Medical HMO	CIGNA HMO	www.cigna.com	(800) 244-6224
Medical HMO	HealthSpring HMO	www.myhealthspring.com	(800) 881-9466
Dental Plan	Delta Dental of Tennessee	www.deltadentaltn.com	(800) 223-3104 (615) 255-3175
Vision Plan	VSP	www.vsp.com	(800) 877-7195
Basic Life and AD&D Insurance	Metro Human Resources	www.nashville.gov	(615) 862-6700
Supplemental and Dependent Life Insurance	Aetna Life Insurance Co.	Link through www.nashville.gov	(800) 523-5065
Short-Term Disability (STD) Insurance	Standard Insurance Company	Link through www.nashville.gov	(888) 494-9491
Long-Term Disability (LTD) Insurance	Standard Insurance Company	Link through www.nashville.gov	(888) 494-9491
Long-Term Care Insurance	Prudential Insurance Company	www.prudential.com/gltc	(800) 732-0416
Flexible Spending Accounts (FSAs)	FlexServ (Ceridian)	www.ceridianfsa.com	(800) 366-3130 (877) 799-8820
Metro Pension Plan	Metro Human Resources	www.nashville.gov	(615) 862-6700
MetroMax 457 Deferred Compensation Plan	ING (plan administrator)	www.ingretirementplans.com/custom/nashville	(800) 584-6001 (615) 291-8317
Social Security and Medicare	Social Security Administration	www.ssa.gov	Your local Social Security office
Employee Assistance Program (EAP)	Horizon Health	www.ohca-eap.com	(800) 955-6422 (615) 292-4327
In-Service Training	Metro Human Resources	www.nashville.gov	(615) 862-6640
Other Information	Metro Human Resources	www.nashville.gov	(615) 862-6700

Updates for 2005

Long Term Care Insurance	Your Enrollment Packet includes information on long-term care (LTC) insurance for your *Inside Metro Human Resources Guide* (3-ring binder). Added last spring, LTC insurance is the latest addition to the Metro benefit program. It provides a measure of financial protection if you or a family member require long-term care in any one of a variety of settings, including nursing homes, assisted-living facilities, hospice facilities, or even your own home. **Long-term care is not just for retirees or those nearing retirement. About 40% of people who receive long-term care are between the ages of 18 and 64.** For details on this valuable coverage, read the LTC insert in your Enrollment Packet or contact the insurance carrier (see previous page for contact information). And remember to put the LTC Insurance section into your *Inside Metro Human Resources Guide*, behind the Income Protection tab.
Other Updates	Your *Inside Metro Human Resources Guide* was designed to be updated easily and economically. Other than the new insert on long-term care insurance (see above), there are relatively few updates to the binder contents for 2005. To help control costs, we have printed these updates on a single sheet, which is part of your Enrollment Packet. **Please read the updates carefully and note the changes in the appropriate pages of your binder.**
Flexible Spending Accounts	Your Enrollment Packet also includes a guide on Flexible Spending Accounts (FSAs). At a time when stretching your benefit dollars is more important than ever, **FSAs allow you save from 20% to 40% or more on eligible health and dependent care expenses.** Don't miss this chance to learn more about these unique accounts and how they can make your hard-earned dollars go farther. And keep in mind that Annual Enrollment is the only time you can set up an FSA during the year unless you have an eligible change in status. See your *FSA Guide* for details, and file the FSA Guide in your benefits binder for reference.

Is Your Beneficiary Information Current?

To update your beneficiary information for life insurance, complete the form on Page 17 and submit it with your 2005 Election Form or whenever you have a change of beneficiary for life insurance in the future.

To change beneficiaries for other benefits, contact Metro Human Resources at (615) 862-6700.

How to *Enroll* in 2005 Benefits

- ❑ Review your *Personal Benefit Statement* and refer to it when electing your 2005 benefits. You'll find your Personal Benefit Statement attached to your 2005 Benefit Election Form.

- ❑ Refer to this *Enrollment Guide* for:
  - 2005 insurance rates
  - 2005 medical plan highlights
  - Beneficiary Designation Form for supplemental and dependent life insurance
  - Flexible Spending Account worksheet
  - Evidence of Insurability Form (required if you are enrolling in supplemental life or dependent life for the first time during this Annual Enrollment or increasing supplemental life coverage by $20,000 or more)
  - Medical History Statement (required if you are enrolling in long-term disability for the first time during this Annual Enrollment)
  - Contact information for each Metro benefit

- ❑ For benefit details, read your *Inside Metro Human Resources Guide* (binder) or contact the insurance carriers or Metro Human Resources. Be sure to update your binder with the information in your Enrollment Packet.

- ❑ Attend an Ask & Enroll Day (attendance is optional) to talk one-on-one about your benefits with the insurance carriers and Metro Human Resources representatives. You can also submit your 2005 Election Form at any Ask & Enroll Day.

- ❑ Complete the *2005 Benefit Election Form* (see accompanying document) and **submit it between October 11 and October 29, 2004,** by any of the following means:
  - In person (by 4:30 p.m.) to Metro Human Resources (222 Third Avenue North, Suite 200, Nashville)
  - In person at any Ask & Enroll Day (see Page 7 for a calendar)
  - By fax at **(615) 880-3401** (fax only the Election Form side of the page, not the instruction side)
  - Online at **www.nashville.gov** (click "Annual Enrollment")

- ❑ If you have no changes to your benefit elections or dependent information for 2005 and you do not wish to take advantage of the tax savings of the Flexible Spending Account (FSA) benefit, you do not need to submit an Election Form during this Annual Enrollment. However, please read the Election Form instructions carefully before deciding whether you need to submit an Election Form.

- ❑ Keep a personal copy of all forms you submit. A confirmation statement of your 2005 benefit elections will be mailed to your home at the close of Annual Enrollment.

Remember: Annual Enrollment begins October 11 and ends October 29.
Your 2005 Election Form must be submitted during this period.

Ask & Enroll Days

Questions about your 2005 benefits and enrollment? Want to talk one-on-one with plan representatives about your benefits and have the option to enroll on the spot? Then come to any one of eight convenient Ask & Enroll Days starting October 12 (see calendar below).

At Ask & Enroll Days, representatives from the insurance carriers and Metro Human Resources will be on hand to answer questions and collect Election Forms. Be sure to bring your Enrollment Packet with you. Or, if you already know what changes you want for 2005, just drop off your completed 2005 Election Form. It's that easy.

Ask & Enroll Days are voluntary. You don't have to attend to enroll (see Page 6 for other enrollment options). If you can attend, you should, especially if you have questions about your benefits. Or, if you can't go to an Ask & Enroll Day, watch Nashville Cable Channel 3 for more information about 2005 benefits and enrollment (see your cable listings for times).

Ask & Enroll Days Calendar

Date	Time	Location*
Tuesday, Oct. 12	7 a.m. – 4 p.m.	General Hospital, Room 9 BC 1818 Albion Street
Wednesday, Oct. 13	7 a.m. – 4 p.m.	Metro Police – South Station Community Room 5101 Harding Place
Thursday, Oct. 14	1 p.m. – 8 p.m.	Antioch Community Center 5023 Blue Hole Road
Friday, Oct. 15	7 a.m. – Noon	Metro Water Department, Community Room 1616 Third Avenue North
Tuesday, Oct. 19	1 p.m. – 8 p.m.	Metro Police – North Station Community Room 2231 26th Avenue North
Wednesday, Oct. 20	7 a.m. – 4 p.m.	Metro Public Works Department Roll Call Room 740 South 5th Street
Thursday, Oct. 21	1 p.m. – 7 p.m.	Randalls Learning Center 3501 Byron Avenue
Friday, Oct. 22	8 a.m. – 1 p.m.	Metro Parks Department Recreation Conference Room 2565 Park Plaza

***For directions, call Metro Human Resources at (615) 862-6700.**

2005 Medical and Dental Plan Insurance *Rates*

Effective January 1, 2005

See the category that applies to you (General Employee or Public School Employee). This is what you pay for health coverage — about 25% of the total cost of coverage. **Metro pays the other 75% for you.**

	Coverage Level	BC/BS PPO	CIGNA HMO	HealthSpring HMO
Medical Plan Rates for General Employees Semi-Monthly Rates[2]	Single (individual)	$52.50	$50.74	$45.62
	Family	127.50	123.39	111.75
	Split [1]	75.00	72.65	66.13
	Single (9 months)	70.00	67.65	60.83
	Family (9 months)	170.00	164.51	149.00
	Split [1] (9 months)	100.00	96.86	88.17

Medical Plan Rates for Public School Employees Biweekly Rates	**10-Month Employee**			
	Single	$60.00	$57.99	$52.14
	Family	145.71	141.01	127.71
	Split [1]	85.71	83.02	75.57
	12-Month Employee			
	Single	$48.46	$46.84	$42.11
	Family	117.69	113.89	103.15
	Split [1]	69.23	67.06	61.04

		Single	Family
Dental Plan Rates	General Employee (9 Month) – semi-monthly rates [2]	$0.00	$21.22
	General Employee (12 Month) – semi-monthly rates [2]	0.00	15.92
	Public Schools (10 Month) – biweekly rates	0.00	18.19
	Public Schools (12 Month) – biweekly rates	0.00	14.70

[1] Split coverage is available to Metro employees and pensioners who: 1) are married to a Metro employee or pensioner, 2) are enrolled in the same Metro medical and/or vision plan as their spouse, and 3) enroll dependent child(ren) in the plan(s). (All three requirements must be met.)

[2] For those who move to biweekly pay (26 pay periods) in 2005, premiums will continue to be deducted from 24 pay periods.

2005 Optional Benefit Plan Insurance *Rates*

Effective January 1, 2005

You pay the full cost of optional benefits at group rates. Group rates are generally lower than individual rates.

		Single	Family	Split [1]
Vision Plan Rates	General Employee (12 month) – semi-monthly rate [2]	$2.65	$5.38	$2.73
	General Employee (9 month) – semi-monthly rate [2]	3.54	7.18	3.64
	Public School Employee (12 month) – biweekly rate	2.45	4.97	2.52
	Public School Employee (10 month) – biweekly rate	3.18	6.46	3.28

[1] Split coverage is available to Metro employees and pensioners who: 1) are married to a Metro employee or pensioner, 2) are enrolled in the same Metro medical and/or vision plan as their spouse, and 3) enroll dependent child(ren) in the plan(s). (All three requirements must be met.)

[2] For those who move to biweekly pay (26 pay periods) in 2005, premiums will continue to be deducted from 24 pay periods.

Supplemental Life Insurance Rates [3,4]

Age	Monthly Rate Per $10,000 of Supplemental Life
0 to 29	$0.30
30 to 34	$0.50
35 to 39	$0.60
40 to 44	$0.80
45 to 49	$1.50
50 to 54	$2.30
55 to 59	$3.80
60 to 64	$4.80
65 to 69	$6.50
70 and over	$7.40

Dependent Life Insurance Rates [4]

Note: To enroll in dependent life, you (the employee) must enroll in supplemental life.

Monthly Rate for Dependent Life
$1.90 per month • $10,000 coverage for spouse • $5,000 coverage for each child • No limit on number of dependents

[3] You may buy supplemental life coverage of up to three times your Metro salary, in increments of $10,000, to a maximum of $200,000.

[4] You must submit an Evidence of Insurability Form if you are enrolling in supplemental or dependent life insurance for the first time during this Annual Enrollment, or if you are increasing your supplemental life coverage by $20,000 or more.

Short-Term Disability (STD) Insurance Rates [5]

[5] Short-term disability (STD) rates are based on your Metro pay. Following are **sample** monthly rates. To calculate your monthly STD insurance rate, multiply 0.0502 times your **weekly** (not monthly) pay.

Hourly Earnings	Weekly Earnings	Sample Monthly Rate
$10	$400	$20.08
$15	$600	$30.12
$20	$800	$40.16

Long-Term Disability (LTD) Insurance Rates [6]

[6] Long-term disability (LTD) rates are based on your Metro pay. Following are sample monthly rates. To calculate your monthly LTD insurance rate, multiply 0.0049 times your monthly (not weekly) pay. You must complete the Medical History Statement if you are enrolling for long-term disability for the first time during this Annual Enrollment.

Hourly Earnings	Monthly Earnings	Sample Monthly Rate
$10	$1,750	$8.58
$15	$2,600	$12.74
$20	$3,500	$17.15

Long-Term Care (LTC) Insurance Rates	Contact Prudential at **www.prudential.com/gltc** or call **800-732-0416**.

2005 Medical Plan Highlights

Note: This chart is a summary only. If the information differs from that of the official plan documents, the plan documents will govern. For details, contact the insurance carrier.

Covered Benefit	BC/BS PPO In-Network Blue Network P	BC/BS PPO Out-of-Network [1] Provider of Your Choice	Cigna HMO	HealthSpring HMO [2]
Deductible	None	$200 individual, $600 family. **Note:** deductible required for out-of-network care and services.	None	None
Coinsurance	Plan pays 80% of maximum allowable charges for most services	Plan pays 60% of maximum allowable charges for most services after deductible. You pay any amount over maximum allowable charge.	None	None
Annual out-of-pocket maximum	$1,000 individual, $2,000 family	$5,000 individual, $10,000 family	$1,000 individual, $2,000 family Note: Only mental health and substance abuse copays apply to out-of-pocket max	$2,000 individual, $4,000 family Note: Medical, surgical and behavioral health copays apply to out-of-pocket max
Hospital (semi-private room, supplies, drugs, X-rays, tests)	80% of maximum allowable charges	60% of maximum allowable charges	100%	100%
Emergency Room care	80% after $50 copay	60% of maximum allowable charges after $50 copay	$50 copay (life- or limb-threatening or if referred by PCP)	$50 copay (true emergency); must contact PCP next business day
Surgery, office visits, anesthesia, consults, treatment, second surgical opinion	80% after $10 copay per visit	60% of maximum allowable charges after $10 copay per visit	100% after $10 copay per visit with PCP or specialist	100% after $10 copay with PCP and specialist
Maternity	80% of maximum allowable charges after $10 copay per visit	60% of maximum allowable charges after $10 copay per visit	$10 copay for first visit to confirm pregnancy; all later visits 100%	$10 copay for first OB visit; all later visits 100%
Prescription drugs	$10 copay for generics, $20 copay for brand names; certain drugs require pre-authorization; quantities of some drugs may be limited Maintenance drugs: 102-day supply for 2 copays (prescriptions must be on BCBST maintenance drug list); drugs not on the maintenance list limited to a 34-day supply at retail pharmacies Home Delivery Program (mail-order): 102-day supply for 2 copays	$10 copay for generics plus charges above usual costs; $20 copay for brand names plus charges above usual costs; certain drugs require pre-authorization; quantities of some drugs may be limited Maintenance drugs: 102-day supply for 2 copays (prescription must be on BCBST maintenance drug list); drugs not on the maintenance list limited to a 34-day supply at retail pharmacies	$10 copay for generic (30-day supply); $20 copay for brand name (30-day supply). If generic is available but you request brand name, you pay $20 copay plus difference between generic and brand name. Coverage for formulary drugs only unless pre-authorized. Mail-order program: 90-day supply for 3 copays less $5 (coverage for formulary drugs only)	$10 copay for generic, $20 copay for preferred brand name, $35 copay for non-preferred brand name (30-day supply) Mail order program: 90-day supply for 3 copays; maintenance medications only
Hospice care	80%; must be approved provider	60% of maximum allowable charges	100%	100%; $10,000 calendar year maximum benefit
Home health visits	80% of maximum allowable charges	60% of maximum allowable charges	100%	100% after $10 copay per visit; up to 100 visits per calendar year
Medical equipment (DME, wheel chairs, crutches, etc)	80% of maximum allowable charges	60% of maximum allowable charges	100%	80% of allowed charges, up to a combined benefit limit of $1,500 per calendar year
Preventive physical exams	Not covered	Not covered	100% after $10 copay	100% after $10 copay per visit
Allergy injections	80% of maximum allowable charges after $10 copay for physician consultation	60% of maximum allowable charge after $10 copay for physician consultation	100% after $10 copay per visit or the actual charge, whichever is less	100% after $10 copay per visit
Well-baby care	Routine care until age 2; annual checkups through age 6 paid at 80% after $10 copay	Routine care until age 2; annual checkups through age 6 paid at 60% after $10 copay	100% after $10 copay per visit	100% after $10 copay per visit
Immunizations	Covered if required by public school guidelines through age 6; paid at 80% after $10 copay	Covered if required by public school guidelines through age 6; paid at 60% after $10 copay	$10 copay per visit	$10 copay per visit

[1] Benefits for out-of-network services may be significantly less than in-network benefits. You will be responsible for coinsurance as well as amounts above the maximum allowable charges (as determined by BC/BST).

[2] You must live in one of the following Tennessee counties to enroll in HealthSpring (counties with asterisk have NO participating HealthSpring providers at the time of this printing): Bedford, Cannon, Cheatham, Coffee, Davidson, Dekalb, Dickson, Franklin*, Hickman, Humphreys*, Lawrence*, Lewis*, Macon, Marshall, Maury, Montgomery, Moore*, Robertson, Rutherford, Smith, Sumner, Stewart*, Trousdale, Warren, Wayne*, Williamson, Wilson. **NOTE: HealthSpring will update the list of counties as changes occur. Contact HealthSpring for the latest information.**

Covered Benefit	BC/BS PPO In-Network Blue Network P	BC/BS PPO Out-of-Network [1] Provider of Your Choice	Cigna HMO	HealthSpring HMO [2]
Vision and hearing tests (children under 17)	Not covered	Not covered	$10 copay; services by PCP	$10 copay for screening services by PCP
Skilled nursing facility	80%; 100-day maximum per person per year (must immediately follow 3-day hospital stay)	80%; 100-day maximum per person per year (must immediately follow 3-day hospital stay)	100%; 60-day maximum per person per year no deductible or copays	100%; up to 100 days per calendar year
Radial keratotomy	80% (Lasik surgery not covered)	60% of maximum allowable charge; Lasik surgery not covered	Not covered	Not covered
Custom-built shoes	80%, up to $1,500 lifetime maximum (includes repair and maintenance)	60%, up to a $1,500 lifetime maximum (includes repair and maintenance)	100%, up to $1,500 lifetime maximum (includes repair and maintenance)	80% of allowed charges, up to a combined benefit limit of $1,500 per calendar year. Benefit, annual replacement of shoes and/or inserts for diabetic members only.
Temporomandibular joint syndrome (TMJ)	Surgery covered as any other surgical procedure; 80% in-network; 50% nonsurgical; $2,000 annual maximum; $4,000 lifetime maximum	Surgery covered as any other surgical procedure: 60% out-of-network; 50% nonsurgical; $2,000 annual maximum; $4,000 lifetime maximum	$10 copay per visit for physician and facility charges, inpatient or outpatient; no coverage for appliances or orthodontia (braces)	100% after $10 copay per visit for physician and facility charges; maximum benefit of $2,000 per calendar year for authorized TMJ treatment
Chiropractic services	50% of maximum allowable charge, up to $2,000 maximum per person per year	50% of maximum allowable charges, up to $2,000 maximum per person per year	100% after $20 copay per visit; PCP referral required; maximum of 90 combined chiropractic/physical therapy visits per year	100% after $10 copay per visit; no PCP referral required; 20 visits per calendar year
Acupuncture	50% of maximum allowable charges; $1,000 maximum per person per year	50% of maximum allowable charges; $1,000 maximum per person per year	Not covered	Not covered
Organ transplants	Special provisions apply to transplant coverage	Special provisions apply to transplant coverage	100% for most covered medical expenses and related services	100%; must be pre approved by HealthSpring
Physical therapy	80% of maximum allowable charges	60% of maximum allowable charges	100% after $20 copay per visit; maximum of 90 combined chiropractic/physical therapy visits per year	100% after $10 copay per visit; 30 visits per calendar year
In-line-of-duty	Covered, subject to PPO and non-PPO provisions and copays	Covered, subject to PPO and non-PPO provisions and copays	Covered, subject to copays and HMO guidelines	Covered; subject to copays and HMO guidelines
Selection of physicians	Above benefits apply when you use in-network provider	Above benefits apply when you use out-of-network provider	All care must be received from PCP or PCP-referred specialist (women have open access to participating OB/GYN)	All care must be received from PCP or PCP-referred specialist
Non-routine lab/X-ray (diagnostic services)	80% of maximum allowable charges	60% of maximum allowable charges	Covered under office-visit copay	Covered under office-visit copay
Mental health inpatient	80% of maximum allowable charges; pre-authorization required; maximum of 45 days per year	60% of maximum allowable charges; pre-authorization required; maximum of 45 days per year	100%; maximum of 30 days of combined mental health/substance abuse visits per year	100%; maximum of 30 days of combined mental health/substance abuse per calendar year
Mental health outpatient	80% of maximum allowable charges; no pre-authorization required; 50-visit maximum per year combined with substance abuse	60% of maximum allowable charges; 50-visit maximum per year combined with substance abuse; no pre-authorization required	100% after $10 copay per visit; maximum of 25 visits per year	100% after $10 copay per visit; maximum of 30 visits combined mental health/ substance abuse per calendar year
Substance abuse inpatient	80% of maximum allowable charges; pre-authorization required; 1 admission per 90 days	60% of maximum allowable charges; 1 admission per 90 days; pre-authorization required	100% after $50 copay per day; maximum of 30 days of combined mental health/ substance abuse visits per year	100%; maximum of 30 days of combined mental health/substance abuse per calendar year; detoxification treatments limited to 2 sessions per calendar year (medical detoxification limited to 5 days per session)
Substance abuse outpatient	80% of maximum allowable charges; no pre-authorization required; 50-visit maximum per year combined with mental health	60% of maximum allowable charges; no pre-authorization required; 50-visit maximum per year combined with mental health	100% after $15 copay for the first two visits; $25 copay thereafter, up to 20 visits maximum per year	100% after $10 copay per visit; maximum of 30 visits combined mental health/ substance abuse per calendar year
Group therapy	Covered as mental health outpatient	Covered as mental health outpatient	100% after $15 copay per visit; maximum of 40 combined mental health/substance abuse visits per year	100% after $10 copay per visit; maximum of 30 visits combined mental health/ substance abuse per calendar year

[1] Benefits for out-of-network services may be significantly less than in-network benefits. You will be responsible for coinsurance as well as amounts above the maximum allowable charges (as determined by BC/BST).

[2] You must live in one of the following Tennessee counties to enroll in HealthSpring (counties with asterisk have NO participating HealthSpring providers at the time of this printing): Bedford, Cannon, Cheatham, Coffee, Davidson, Dekalb, Dickson, Franklin*, Hickman, Humphreys*, Lawrence*, Lewis*, Macon, Marshall, Maury, Montgomery, Moore*, Robertson, Rutherford, Smith, Sumner, Stewart*, Trousdale, Warren, Wayne*, Williamson, Wilson. **NOTE: HealthSpring will update the list of counties as changes occur. Contact HealthSpring for the latest information.**

2005 Dental Plan *Highlights*

Note: This chart is a summary only. If the information differs from that of the official plan documents, the plan documents will govern. For details, contact the insurance carrier.

Benefit	Delta Premier Plan In-Network	Delta Premier Plan Out-of-Network	Delta Network Preferred Plan [3]
Calendar year maximum	$1,000 per person	$1,000 per person	No annual maximum
Calendar year deductible	$75 per person; $225 per family	$75 per person; $225 per family	No deductible
Class I — preventive and diagnostic care (initial and periodic exams, cleanings, routine X-rays)	100%; no deductible	100% of the maximum plan allowance[1] (MPA); no deductible	100% for most benefits (except Space Maintainer)
Class II — basic restorative care (fillings, extractions, root canal, periodontal treatment)	80%; no deductible	80% of MPA[1]; no deductible	100% of some services; flat dollar amount set for other services
Class III — major restorative care (crowns, dentures, bridges)	50% after deductible	50% of MPA[1] after deductible	Flat dollar amount set for most services
Class IV — Orthodontia (braces)	50% after deductible; $100 annual deductible[2]; $1,000 lifetime maximum	50% of MPA[1] after deductible; $100 annual deductible[2]; $1,000 lifetime maximum	Flat dollar amount set for all services
Class V — TMJ	50% after deductible; $100 annual deductible[2]; $750 lifetime maximum	50% of MPA[1] after deductible; $100 annual deductible[2]; $750 lifetime maximum	Not a covered benefit

[1] Maximum plan allowance (MPA). You are not responsible for charges over the MPA if you go to a participating Delta dentist. You are responsible for charges over the MPA if you go to a non-participating dentist.

[2] These deductibles are in addition to the plan deductible.

[3] Under the Preferred Plan, you must visit a Preferred Plan dentist or you will not receive benefits, however you do not have to choose a primary care dentist. No Out-of-Network benefits available with this plan.

Forms Section

Flexible Spending Account Worksheet

Under Metro benefits, you have the option to enroll in Flexible Spending Accounts (FSAs). FSAs are special accounts that allow you to set aside tax-free dollars to reimburse yourself for certain health care and dependent care expenses. (For details, see your *Inside Metro Human Resources Guide* or view the new FSA video on the HR section of **www.nashville.gov.**) The worksheets below can help you estimate your health care and/or dependent care FSA election amount(s) for 2005 (minimum of $240 and maximum of $5,000 for <u>each</u> FSA account).

Health Care FSA Worksheet

The health care FSA allows you to use pre-tax dollars to pay for certain health care expenses not covered by your health plan(s). Review receipts from last year for health care expenses you paid out of your own pocket. Using your receipts and this worksheet, estimate the amount you want to elect for your health care FSA for 2005. Only budget for those expenses eligible for reimbursement. Remember, eligible expenses include those for you, your spouse, and your dependents.

Estimated 2004 Expenses	Amount
Deductibles (medical, dental, vision)	$_____
Copayments / coinsurance	$_____
Amounts paid over "reasonable and customary" allowance	$_____
Prescription drugs	$_____
Over-the-counter medications [1]	$_____
Vision care	$_____
Dental / orthodontic care	$_____
Treatments / therapies	$_____
Fees / services / transportation	$_____
Medical equipment	$_____
Psychiatric care	$_____
Assistance for the disabled	$_____
Other eligible expenses	$_____
Total 2004 Health Care Expenses This total gives you an estimate of expenses that might be eligible for reimbursement from a health care FSA in 2005. Consider other factors that will affect your out-of-pocket health care costs during 2005 and adjust the amount accordingly.	$_____

Dependent Care FSA Worksheet

The dependent care FSA allows you to use pre-tax dollars to pay for dependent care services (child care, elder care, and care for disabled spouse) that make it possible for you – and your spouse, if you are married – to work. The dependent care FSA is intended to cover costs of the types of care shown below. It does <u>not</u> cover medical or health care costs for your dependents. (For health care coverage, see the health care FSA worksheet to the left.)

Estimated 2004 Expenses	Amount
Child day care center	$_____
Child nursery and pre-school	$_____
Child after-school care	$_____
Child summer day camps	$_____
Elder day care center	$_____
Elder in-home care	$_____
Disabled spouse in-home care	$_____
Total 2004 Dependent Care Expenses This total gives you an estimate of expenses that might be eligible for reimbursement from a dependent care FSA in 2005. Consider other factors that will affect your out-of-pocket dependent care costs during 2005 and adjust the amount accordingly.	$_____

[1] <u>Certain</u> over-the-counter medications and drugs may be reimbursed from a health care FSA. For details, contact Ceridian, Metro's FSA plan administrator, at **www.ceridianfsa.com or call 800-366-3130**.

CERIDIAN
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Flexible Spending Account Reimbursement Form

FAX TO: 1-877-488-6454 FSA Administrative Services **Page 1 of __**

FROM: For faster service, fax this entire sheet, completed and signed, along with the appropriate documentation. Please complete all applicable spaces.

Employee Name: Last	First	Middle Init.	Social Security Number
			___-___-____

Home Address: Number/Street	Apt #	City	State	Zip

Area Code/Telephone #	Company Name	Division/Location	Client Code
	Metro Govt of Nashville & Davidson Co		**100031**

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. If there is a discrepancy between the total amount of expenses requested above and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

Signature Verification _____ Date _____
Required to process reimbursement

Step 1. Complete the reimbursement form for eligible expenses incurred during your FSA plan year and while you were a participant. Health care expenses must be processed by your insurance company first. An expense is incurred when the service is provided, not when you are billed or pay for the service.

Step 2. Include appropriate documentation with the reimbursement form:

For Health Care expenses, an Explanation of Benefits (EOB) from your insurance company and an itemized bill. The EOB and/or bill must contain the following items in order to be processed:

Total Health Care Expenses
$

- Date of service performed
- Amount of service performed
- Provider of service performed
- Type of service performed

You may attach multiple health care receipts to this form. We will reimburse up to the amount you elected for the year, minus any previous reimbursements.

Around the Clock Service for FSA Participants via www.ceridian-benefits.com

You have direct access to your healthcare and/or dependent care account 24 hours a day.

By accessing our website, www.Ceridian-Benefits.com, or our toll-free automated response system at 1-877-799-8820, you can quickly access your account data and other helpful FSA information. Account data is current as of the previous day's close of business. Customer service professionals are available to assist you 8am to 8pm Eastern Monday through Friday.

For Dependent Care expenses, submit your claim in one of the following ways:

Complete this reimbursement form, which must include:
- Provider signature and address
- SSN or Tax ID #
- Date(s) of service
- Amount Paid

The completed reimbursement form serves as your receipt.

OR

Complete this reimbursement form and attach
A provider receipt, which must include:
- Date(s) of service
- Amount Paid

The provider does not need to sign the form.

Total Dependent Care Expenses
$

Dependent Care Provider's Signature	SSN or Tax ID #
Dependent Care Provider's Address	Date(s) of Service (include year) From: _____/_____/_____ To: _____/_____/_____

You may submit one reimbursement form for multiple service dates.
We will reimburse up to the amount you have deposited in your account to date, minus any previous reimbursements.

Step 3. Fax this entire form along with the appropriate documentation to 1-877-488-6454.
Requests received via FAX will be processed the latter of two business days after receipt or prior to your next scheduled reimbursement date. If you prefer, mail completed form and documentation to: FSA Claim Administration, P.O. Box 534134, St. Petersburg, FL 33747-4134. Please keep your original receipts. Claims received via mail may require one additional day for processing.

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Aetna Life Insurance Company
Designation of Beneficiary

Forward to:
Metro Human Resources
Attention: Benefit Services
P.O. Box 198589
Nashville, TN 37219-0589

Before executing this form refer to the other side. Please keep a copy for your records.

Group Policyholder Name	Group Policy Number		Employee/Retiree Social Security Number
Metropolitan Government of Nashville and Davidson County	**879732**	☐ Employee ☐ Retiree	

Employee/Retiree Name and Address	Coverage(s) this form applies to:
	• Basic Life Insurance • Supplemental Life

Subject to the terms of the above numbered Group Policy(ies), I request that any sum becoming payable by reason of my death be payable to the following beneficiary(ies). It is my understanding that this designation shall operate so as to revoke all designations of beneficiary and all election of optional methods of settlement previously made by me under said Policy(ies). If this Designation of Beneficiary refers only to a Group Life Insurance Policy and if I am also insured for Supplemental and/or Group Accidental Death coverage, this designation shall apply to those coverages. This Designation of Beneficiary is subject to all "Conditions" shown on the reverse side of this form.

Employee/Retiree Signature	Date

Beneficiary Name and Address ☒ **Primary Beneficiary*** ☐ **Basic Life Insurance** ☐ **Supplemental Life Insurance**

Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

Beneficiary Name and Address ☐ **Primary Beneficiary* or** ☐ **Contingent Beneficiary**** ☐ **Basic Life Insurance** ☐ **Supplemental Life Insurance**

Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

Beneficiary Name and Address ☐ **Primary Beneficiary* or** ☐ **Contingent Beneficiary**** ☐ **Basic Life Insurance** ☐ **Supplemental Life Insurance**

Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

Beneficiary Name and Address ☐ **Primary Beneficiary* or** ☐ **Contingent Beneficiary**** ☐ **Basic Life Insurance** ☐ **Supplemental Life Insurance**

Relationship	Social Security Number	Date of Birth (MM/DD/YYYY)	Percentage

*If more than one Primary Beneficiary is named, the Primary Beneficiaries shall share equally unless otherwise indicated above.
**Contingent Beneficiary(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If you are naming more than one Contingent Beneficiary at 100% each, please indicate 1st contingent, 2nd contingent, 3rd contingent, etc. in the order of precedence.
SPOUSAL CONSENT FOR COMMUNITY PROPERTY STATES ONLY**- See Conditions on reverse side of form. **Tennessee is not a community property state and does not require spousal consent.**
***Please note that an employee/retiree is under no obligation to complete the Spousal Consent section of this form.

I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse Signature ______________________________ Date ____________

- Unless otherwise expressly provided in this Designation of Beneficiary form, if any named beneficiary predeceases me, the life proceeds shall be payable equally to the remaining named beneficiary or beneficiaries. If no named beneficiary survives me, any sum becoming payable under said Group Policy(ies) by reason of my death shall be payable as prescribed in said Group Policy(ies).
- If this Designation of Beneficiary provides for payment to a trustee under a trust agreement, Aetna Life Insurance Company shall not be obliged to inquire into the terms of the trust agreement and shall not be chargeable with knowledge of the terms thereof. Payment to and receipt by the trustee shall fully discharge all liability of said Insurance Company to the extent of such payment.
- If you live in one of the following community property states - Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin – your spouse may have a legal claim for a portion of the life insurance benefit under state law. If you name someone other than your spouse as beneficiary, payment of the death benefit may be delayed until your spouse's claim is resolved. If you make the beneficiary someone other than your spouse, it may be a good idea to complete the spousal consent section, which allows the spouse to waive his or her rights to any community property interest in the benefit.

Instructions

- Please use only black ink to complete this form.
- If you make a mistake in completing this form, line out the erroneous information, add the correct information and initial the correction. **The printed material on this form should not be deleted or altered in any way.**
- In all cases, the relationship of the beneficiary and the beneficiary's social security number should be included with the beneficiary designations.
- If beneficiary is to be contingent, be sure to check the appropriate box. A Contingent Beneficiary will receive benefits only if the Primary Beneficiary(ies) do not survive the insured. If naming more than one Contingent Beneficiary at 100% each, please indicate 1st contingent, 2nd contingent, 3rd contingent, etc.
- If a married woman is named beneficiary, her full legal name should be shown. **For example:** Mary J. Smith, not Mrs. John J. Smith. Likewise, if this form is to be signed by a married woman, she should sign her full legal name.
- If a minor child is named beneficiary, the date of birth along with the social security number must be given.
- When two or more beneficiaries are named, and they are not to share the benefits equally, enter the percentage each beneficiary is to receive on the form in the space provided. **Dollars and cents should not be specified. When added together, the sum of the percentages going to the two or more named beneficiaries should not total more than 100%.**
- If a trustee is named beneficiary, show the exact name of the trust, date of the trust agreement, and the name and address of the trustee. **For example:** The John J. Smith Revocable Life Insurance Trust, dated January 1, 1994. John Smith Trustee, 123 Apple Lane, Hartford, CT 06006.

Evidence of Insurability Statement
Life Coverage
Aetna Life Insurance Company

Read this instruction page carefully. Do NOT mail your completed statement to Metro. Make a copy for your records and send the original to Aetna. Aetna may contact you directly to request additional information upon receipt of this completed statement.

Instructions

Employee

Read the Privacy Notice and Misrepre-sentation section on "Page 2 of 4" of the Insurability Statement before completing.

Please Print

Complete the following items in Section A:

- Item A2 – Your Social Security Number
- Item A6 – Employee Date of Hire
- Item A7 – Employee Telephone Numbers
- Item A8 – Life Coverage Applied For (a, b and c)
- Item A9 – Reason for Requested Change and Annual Metro Earnings

Complete Section B. ***Be sure that*:**

- All items are completed.
- Only the names of individuals requesting coverage at this time are listed (B1). Check appropriate boxes regarding dependent child coverage, if applicable (B1a and B1b).
  - Height and Weight ***must*** be provided or this form will be returned unprocessed for your completion (B1).
- Complete dates and details are given for all "No" answers to questions B1a and B1b and for all "Yes" answers to questions in B2, Statement of Health (B3).
- The form is signed by you. If you are requesting spouse coverage, the spouse's signature is also required. Read the Certification, Acknowledgment and Authorization prior to signing the form (bottom of Section B).

Make a copy for your records. Mail the **original** to:

Aetna Life Insurance Company
Consumer Services
151 Farmington Avenue
Hartford, CT 06156-7318

1-800-523-5065

If a final underwriting decision cannot be made within six months, Aetna reserves the right to request a new Evidence of Insurability Statement.

Please Note: If this form is not completed in its entirety *and* signed, it will be returned unprocessed completion.

Privacy Notice

In evaluating your insurability, we (Aetna) will rely primarily on the health information you furnish to us in this Evidence of Insurability Statement. In addition, however, we may ask you to take a physical examination, or request additional medical information about you from any of the sources specified in the authorization on Page 4 of 4 of this form.

Disclosure of Information to Others

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. For example, Aetna Life Insurance Company may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may apply for coverage, or to whom a claim for benefits may be submitted. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding), and to request correction, amendment or deletion of recorded personal information in states which provide such rights and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right, or if you wish to have a more detailed explanation of our information practices, please contact:

Aetna Life Insurance Company
Medical Underwriting Department
151 Farmington Avenue
Hartford, CT 06156-2975

Under New Mexico law, a resident of New Mexico has the right to register as a "protected person" in connection with disclosure of confidential domestic abuse information. If you wish to exercise this right, write to the address shown above.

Misrepresentation

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison, and substantial civil penalties. Many other states have similar laws.

Attention Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

Attention Florida and Virginia Residents: Any person who knowingly and with intent to defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention DC Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

A. Plan Sponsor/Employer: Complete this Section - Please print.

1. Control Number	Suffix	Account	2. Employee Social Security Number
879372	11	011	- -

3. Plan Sponsor/Employer Name & Address	4. Employee Name & Address
ATTN: **Metropolitan Government of Nashville & Davidson County**	
Street	Street
City State ZIP Code	City State ZIP Code

5. Plan Sponsor - Authorized Rep. Telephone Number	6. Employee Date of Hire (MM-DD-YY)	7. Employee Telephone Numbers
( ) -		Work ( ) - Home ( ) -

8. **Life Coverage Applied for:** ☐ Employee ☐ Spouse ☐ Dependent

	Employee Supplemental Life (Employee Paid)	Spouse Life (Employee Paid)	Dependents Life (Employee Paid)
a. **Current** Amount of Life Insurance Coverage?	$	$	$
b. **Additional** Amount of Life Insurance Coverage requested?	$	$	$
c. Resulting **Total** Life Insurance Amount if Approved (a + b)?	$	$	$

9. Reason for Requested Coverage.

☐ Salary Increase ☐ Change in Multiple ☐ Late Applicant ☐ Change in Coverage Amount ☐ Life Event/Status Change

☐ Other (Please explain) _____

Employee's Annual Earnings: $ _____

B. Employee: Complete this Section - Please print.

1. Only the Names of Individual(s) Requesting Coverage at this Time Should be Listed

Name	Relationship	Birthdate *(MM/DD/YYYY)*	Birthplace (City, State)	Sex	Height (ft., in.)	Weight (lbs.)
Employee:	Self					
Spouse:						
Dependent(s):						

Complete these questions if dependent children are listed above. ***Give dates and details for "No" answers using the space provided in Number 3.***

	Yes	No	
a.	☐	☐	Do all dependent children live in your household and depend solely on you for support?
b.	☐	☐	If any dependent child is age 19 or older, is/are they regularly attending school?

2. Statement of Health for Individual(s) Listed Above. ***Give complete dates and details for "Yes" answers using the space provided in Number 3.***

	Yes	No	
a.	☐	☐	Has any individual been hospitalized within the past two years or is any individual currently scheduled or recommended for an inpatient or outpatient surgical/diagnostic procedure? If yes, list individual(s) and details as to type of procedure in Number 3.
b.	☐	☐	Is any individual currently taking medication(s) for any condition? If yes, list individual(s), diagnosis, medication & dosage, and indicate duration of use in Number 3.
c.	☐	☐	Does any individual use tobacco products (includes cigarettes, cigar, pipe and chewing tobacco)? If yes, list individual(s) and product(s) used in Number 3.

B. Employee: Complete this Section (Continued) - Please print.

2. Statement of Health - Continued. *Give complete dates and details for "Yes" answers using the space provided in Number 3.*

Within the past 10 years have you (or your spouse or dependents) consulted a physician, received medical treatment for or been diagnosed with any of the following illnesses or conditions? ***(If "Yes" is checked, circle all that apply.)***

	Yes	No	
d.	☐	☐	Chest pain, high blood pressure, stroke, disease of the heart, circulatory system or blood disorder?
e.	☐	☐	Cancer, tumor, lupus, rheumatoid arthritis, AIDS, HIV* related disorders or any other immune system deficiency disorder?
f.	☐	☐	Respiratory: bronchitis, asthma, emphysema, any other lung disorder/disease?
g.	☐	☐	Diabetes, kidney disease, disorder of the pancreas, liver, intestines or stomach?
h.	☐	☐	Nervous system: epilepsy, paralysis, progressive/chronic neuromuscular diseases, substance abuse (alcohol/drugs) or mental illness?

*AIDS (Acquired Immune Deficiency Syndrome) is a serious disease. It is caused by a virus called HIV (Human Immuno-deficiency Virus). The virus is found in some human body fluids of infected people, most notably in semen and blood. If the AIDS virus finds its way into the bloodstream, it can damage the body's defenses against disease, resulting in life-threatening diseases. There is no known cure.

3. Use this space to provide the details for **"No" answers in Number 1** and **"Yes" answers in Number 2**. Be specific as to individual(s) affected.

Ques. No.	Individual Affected	Diagnosis	Date of Onset	Details/ Symptoms	Treatment(s) Received	Full Recovery Date

☐ *Check here if you are providing additional information on a separate attachment.*

Certification: I certify these answers and statements are complete and true to the best of my knowledge and belief. I will inform Aetna of any material changes to the information provided which take place between the time the form is completed and the time coverage becomes effective. I agree that this document shall become a part of my request for group coverage and I acknowledge that I have retained a copy of this document as completed by me.

Acknowledgment: I understand that, to the extent permitted by state law, false statements may result in the denial of claims or in my insurance coverage being void as of its effective date with no benefits payable. I understand that conditions which are disclosed on this form may be subject to all conditions of my employer's Plan including any preexisting condition limitations, fraud provisions and employee actively at work and dependent health condition requirements. My signature indicates that I have reviewed all information and statements on this form for completeness and accuracy.

Authorization: To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical or hospital service and prepaid health plans, and employers: You are authorized to provide Aetna Life Insurance Company (Aetna) information concerning healthcare, advice, treatment or supplies (including those related to mental illness and/or AIDS/ARC/HIV) provided me or any members of my family for whom coverage has been requested. (Minnesota residents are not required to provide information concerning results of AIDS/ARC/HIV tests performed on a criminal offender or a crime victim.) I acknowledge that information obtained from any or all of the above may result in further underwriting investigation. This information will be used for the purpose of determining eligibility for coverage. This authorization will be valid for thirty (30) months from the date signed (Minnesota residents twelve [12] months)**. I acknowledge that I have read the Privacy Notice and Misrepresentation section shown on "Page 2 of 4" of this form and know that I have a right to receive a copy of this authorization upon request.** I agree that a photographic copy of this authorization is as valid as the original.

Employee's or Authorized Person's Signature (*Required at all times*)	Date	Spouse's or Authorized Person's Signature (*Required if spouse coverage is requested*.)	Date

Standard Insurance Company
Medical Underwriting, 41 Donald B. Dean Drive South Portland ME 04106-6914

Medical History Statement

For Residents of: AR, CO, DC, KY, LA, NJ, NY, OH, PA, TN

DIRECTIONS FOR APPLYING FOR COVERAGE

This form must be completed when Evidence Of Insurability is required. To apply for coverage (as a Member/Employee, Spouse or Child), read the Information Practices Notice(s). Then complete all items, date, and sign as instructed. Send the original to Standard Insurance Company, at the address above. Please keep a copy for your records.

MEMBER/EMPLOYEE INFORMATION

Name of Group			Group Number	
Member/Employee Name			Birthdate (Mo/Day/Year)	Date Hired (Mo/Day/Year)
Occupation	Salary	Social Security Number	Check who is Applying (One per form) ☐ Member/Employee ☐ Spouse ☐ Child	

APPLICANT INFORMATION

Applicant's Name (Person to be insured)			Address (Street, City, State, Zip)	
Sex ☐M ☐F	Birthdate (Mo/Day/Year)	Birthplace	Social Security Number	Work Phone ( ) Home Phone ( )

APPLICATION INFORMATION

Type of Application *(check one)* ☐ Initial ☐ Increase in coverage ☐ Late Application

Check the insurance coverage you are requesting.

☐ Short Term Disability

☐ Long Term Disability _____ (Current Amount In Force, if any) + _____ (Additional Amount Requested) = _____ (Total Amount Requested)

☐ Life _____ (Current Amount In Force, if any) + _____ (Additional Amount Requested) = _____ (Total Amount Requested)

☐ Dependents Life _____ (Current Amount In Force, if any) + _____ (Additional Amount Requested) = _____ (Total Amount Requested)

MEDICAL HISTORY STATEMENT QUESTIONS

Check yes or no for each of these questions, and give details for any "yes" answers. Attach a separate sheet if necessary.

1. Have you had any physical, mental or emotional condition, injury, sickness, or surgery in the past 5 years? ☐ Yes ☐ No
2. Have you consulted or been attended by a physician or practitioner for any cause in the past 5 years? ☐ Yes ☐ No
3. Are you now unable to work full-time because of any physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
4. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
   - A. High blood pressure, cardiovascular disease, heart ailment, arteriosclerosis, or stroke? ☐ Yes ☐ No
   - B. Mental condition, depression, epilepsy, or nervous system disorder? ☐ Yes ☐ No
   - C. Cancer, diabetes, or nephritis? ☐ Yes ☐ No
   - D. Arthritis, strained or injured back, slipped disc, or any bone, joint, or muscle disorder? ☐ Yes ☐ No
   - E. Lung, kidney, stomach, genital, urinary, liver, pancreas, or intestinal ailment? ☐ Yes ☐ No
   - F. Blindness or deafness? ☐ Yes ☐ No
   - G. An immune system disorder not related to Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
5. Has a medical professional ever diagnosed you as having or prescribed medication to you for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or HIV infection? ☐ Yes ☐ No
6. Have you sought or received advice or treatment for the use of alcohol or drugs in the past 10 years? ☐ Yes ☐ No
7. In the past 10 years have you had a persistent cough, unintentional weight loss of 10 pounds or more, persistent fatigue, persistent lymph node enlargement, prolonged night sweats, pneumonia, lesions, or growths? ☐ Yes ☐ No
8. Do you take medication for any physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
9. Do you plan any operation or visit to a doctor or practitioner for an existing physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
10. Have you ever been declined for insurance or offered a rated or restricted policy, either as a new policy or reinstatement? ☐ Yes ☐ No
11. Are you now pregnant? ☐ Yes ☐ No

Height	Weight	Physician or Medical Facility with Applicant's Complete Medical Records
		Name and Full Mailing Address

Applicant Name	Social Security Number

Describe below any "yes" answers. (Please provide the entire question number.)

Question Number	*Description of Injuries, Disorders and Operations*	*Month/Year*	*Duration*	*Final Result*	*Physicians Consulted, City & State*

ACKNOWLEDGMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION *(Please read carefully)*

- I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any attachments, are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by Standard Insurance Company, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, Standard Insurance Company's liability is limited to the return of any premium which may have been paid.
- To any physician, health care provider, hospital, insurance or reinsurance company, the Medical Information Bureau, Inc. (MIB), or any employer: I authorize you to release to Standard Insurance Company or its reinsurers all medical information you have about me including medical history, diagnosis, prognosis and treatment of any physical, mental or emotional condition. I understand that Standard Insurance Company will use the information obtained by this authorization to determine my eligibility for group insurance coverage. I further authorize Standard Insurance Company to release this information to its reinsurers, MIB, and to other insurance companies to which I have applied for insurance coverage or benefits.
- I understand that if my application is approved, premiums shall be paid in accordance with the provisions of the Group Policy(ies), and my coverage will be subject to all terms and conditions of the Group Policy(ies) and state limitations.
- For Member/Employee: If I currently have a Life and/or Trust Life beneficiary designation on file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designation(s) on file or I wish to change the name of the current beneficiary(ies), I will contact my plan administrator.
- I understand that insurance on a Spouse or other Dependent, if any, is payable to the Member/Employee, if living, or as provided under the terms of the Group Policy(ies).
- I acknowledge that I have read and received the Information Practices Notice, the applicable Fraud Notice, and I have kept a copy of this Medical History Statement.
- I understand a copy of this authorization will be provided to me, or my authorized representative, upon request. This authorization will remain valid one year from the date below. A photocopy of this authorization shall be as valid as the original.
- I understand that I have the right to revoke this authorization at any time by sending a written statement to Standard Insurance Company. I further understand that the revocation of the authorization, or the failure to sign the authorization, may impair Standard Insurance Company's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.

Signature of Applicant (or Member/Employee for Dependent Child)	**Dated**

Note: Declinations do not affect either Guarantee Issue Amounts not subject to Evidence Of Insurability or other coverages already in force with Standard Insurance Company.

Applicant Name	Social Security Number

INFORMATION PRACTICES NOTICE

- To help us determine your eligibility for group insurance, we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (Medical Information Bureau). We will use the authorization you signed on this form when we seek this information.
- MIB (MEDICAL INFORMATION BUREAU) – Information we collect about you is confidential. However, Standard Insurance Company or its reinsurers may make a brief report to the MIB. MIB is a nonprofit corporation. It exchanges information among its member life insurance companies. If you later apply to another MIB member company for life or health insurance coverage, or if you submit a claim for benefits to such member company, MIB will supply the member company with any information it has about you in its files. This will be done only upon the member company's request. Standard Insurance Company or its reinsurers may also release information about you to Standard Insurance Company's reinsurers or to other insurance companies to whom you have applied for life or health insurance or made claim for benefits.
- MIB will disclose any information it has about you at your request. If you believe that the information MIB has about you is incorrect, you may contact MIB and request a correction. Your request for correction will be handled by MIB in accordance with the procedures outlined in the federal Fair Credit Reporting Act. The address of the MIB information office is: P.O. Box 105, Essex Station, Boston, Massachusetts 02112. MIB's telephone number is (617) 426-3660.
- DISCLOSURE TO OTHERS – The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.
- YOUR RIGHTS – You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us, at Medical Underwriting, Standard Insurance Company, 41 Donald B. Dean Drive, South Portland, Maine 04106-6914 or call 1-888-456-3505.

FRAUD NOTICE

- FOR RESIDENTS OF ARKANSAS, DISTRICT OF COLUMBIA, KENTUCKY, OHIO, TENNESSEE: Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.
- FOR RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who kindly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- FOR RESIDENTS OF NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- FOR RESIDENTS OF NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- FOR RESIDENTS OF PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PLEASE RETAIN A COPY FOR YOUR RECORDS

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NOTES

Metro Nashville Human Resources
Annual Enrollment Guide
for 2005 Benefits